STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G155	A. BUILDING _____ B. WING _____	06/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	2268 SUDBURY ROAD, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Surveyor: 12301 A recertification survey was conducted from June 23, 2011, through June 24 ,2011. A random sampling of three clients was selected from a residential population of five males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with staff and clients in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000	Received 7/18/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation and interview, the facility failed to ensure privacy during personal needs, for one of the five clients in the facility. (Client #5) The finding includes: On June 23, 2011, at 3:55 p.m., Client #5 was observed in his bedroom changing his clothes with the door wide open. Client #5 was observed standing in up next to his bed wearing a t-shirt and underpants. Two staff were observed in the bedroom while Client #5 was changing. Approximately 30 seconds after the observation, one of the staff members left the bedroom but failed to close the door. Shortly after the staff	W 130	7/18/11 W 130 In the future the staff will ensure that all individuals' privacy rights are maintained while their personal needs are being delivered. All staff were re trained in individuals' rights and privacy.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Joan F. Sloan — VP Operations — 7/15/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011
FORM APPROVED
OMB NO. 0938-0391

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W 130	Continued From page 1 member left the room, the remaining staff member closed the door. On June 23, 2011, at approximately 7:00 p.m., the qualified intellectual disability professional (QIDP) revealed that staff are required to ensure the clients' privacy at all times.	W 130		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the qualified intellectual disabilities professional (QIDP), for two of the three clients in the sample. (Clients #1 and #3) The findings include: 1. The facility's QIDP failed to ensure clients received continuous active treatment. (See W249) 2. The facility's QIDP failed to ensure program documentation was consistently collected. (See W252) 3. The facility's QIDP failed to ensure adaptive equipment was being furnished, monitored and	W 159	W 159 1. In the future the QDDP will ensure that all staff implement each individual's IPP according to the objectives. 2. In the future the QDDP will ensure that all IPP documentation is completed accordingly. 3. In the future the staff will ensure that each individual uses and maintains their personal adaptive equipment consistently as per the adaptive equipment procedure and protocol. 4. In the future the QDDP will ensure that all staff utilize the appropriate eating utensils as recommended by the OT. The QDDP will ensure that monthly QA is completed on the ISP and IPP records to ensure that all standards are met accordingly. The QDDP will also complete weekly mealtime observations. All the staff were re trained in the individual's IPP, eating utensils, adaptive equipment and documentation.	7/18/11

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W 159	Continued From page 2 maintained as recommended. (See W436) 4. The QIDP failed to ensure guidance to staff was accurate to consistently assist Client #1 during mealtimes. Observation on June 23, 2011, at 6:09 p.m., the one to one staff attempted to hand Client #1 a regular spoon. The qualified intellectual disabilities professional (QIDP) however, told the one to one staff to give Client #1 his built up handle spoon. Continued observation revealed Client #1 was eating pork chops, stuffing, and squash with the built up handle spoon. Interview with the facility' s QIDP on June 24, 2011, at approximately 10:30 a.m. revealed that the client could be given either a regular spoon or a built up handle spoon to utilize during mealtimes. Review of Client #1's occupational therapy (OT) assessment dated July 29, 2010, on June 24, 2011 at 9:15 a.m. however, documented to "discontinue use of the built up utensil. Client uses standard utensils effectively." At the time of the survey, the facility's QIDP failed to provide accurate guidance to staff related Client #1's eating utensils.	W 159		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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W 249	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation, staff interview and record review, the facility's qualified intellectual professional person (QIPD) failed to ensure clients received continuous active treatment, for one of the three clients included in the sample. (Client #1) The findings include: 1. On June 23, 2011, at 3:30 p.m., Client #2 arrived home from his day program. The client was observed to drool heavily from 3:30 p.m. until he left for the Chateau at 6:45 p.m. During the observation, Client #2's one to one staff did not hand the client a paper towel to wipe his mouth until 4:13 p.m. (approximately 43 minutes). At 5:06 p.m., the QIDP asked the one to one staff to keep a napkin on hand to wipe the client's mouth. At 6:13 p.m., the QIDP asked the one to one staff to get a napkin and help Client #2 wipe his mouth. The one to one staff wiped Client #2's mouth then threw the napkin away. After being assisted, Client #2 continued to drool without being encouraged to or assisted by his designated one to one to wipe his mouth. On June 24, 2011, at 11:45 a.m., review of Client #2's individual program plan dated November 1, 2010, revealed an objective for the client to wipe his mouth when drooling is noted. Interview with the QIDP on June 24, 2011, at 10:18 a.m., revealed Client #2's constant and heavy drooling was related to his medical	W 249	W 249 1. In the future the QDDP will ensure that all staff implement each individual's IPP – for drooling, according to the objectives. 2. In the future the QDDP will ensure that all staff implement the BSP as recommended and 1:1 staff remain within arms length of the individual at all times. The QDDP will conduct weekly and monthly QA on the IPP records, along with staff observation, to ensure that all programs are implemented as recommended. See attached in service record	7/18/11

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W 249	Continued From page 4 diagnoses. The QIDP acknowledged that the client's drooling was a concern. When queried regarding the drooling program, the QIDP indicated that the program was conducted informally. Continued review of the client's record, including the IPP, however, failed to indicate the program objective was informal. At the time of the survey, the facility failed to ensure Client #2 was provided supports to implement the aforementioned program as needed. 2. Interview with the qualified intellectual disability professional (QIDP) on June 23, 2011, at 10:15 a.m., revealed that Client # 1 has a one to one staff to address his maladaptive behaviors of PICA, physical aggression, verbal aggression, self-injurious behaviors and bolting. On June 23, 2011, at 3:41 p.m., Client #1 was observed to walk through the kitchen back door and stood outside on the backyard patio while his one to one was in the dining room. A few seconds later, the one to one staff looked up, then walked outside to the client. At 6:37 p.m., Client # 1 walked out of the dining room and into his bedroom while his one to one staff remained in the dining room. Approximately one minute later, the one to one staff was observed walking fast while looking in all the bedrooms until he located the client in his bedroom. Review of Client #1's behavior support plan (BSP) dated July 16, 2010, on June 24, 2011, at 10:00 a.m., confirmed the QIDP's interview of the aforementioned maladaptive behaviors. Further review of Client #1's BSP revealed that the "one to one staff should always be within arms length". The BSP also added that "the one to one staff	W 249		

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W 249	Continued From page 5 should always remain vigilant and aware that [the Client] will attempt to run away from him and leave the premises". At the time of the survey, the facility failed to ensure that Client #1's one to one staff implemented his BSP as recommended.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Surveyor: 27828 Based on staff interview and record review, the facility failed to ensure program documentation was consistently collected, for one of the three sampled clients. (Client #1) The findings include: Record review on June 24, 2011, at 11:45 a.m., revealed Client #1's Individual Program Plan (IPP) dated November 1, 2010, included the following objectives which were not consistently documented. 1. Given physical assistance, the client will return a movie to the library. There was no evidence of documentation for May and June 2011. 2. The client will participate in a picture exchange program to label fundamental basic wants and needs. There was no evidence of documentation	W 252	W 252 1-4. All staff were re-in serviced on the IPPs and program documentation. In the future the QDDP will ensure that all staff implement and complete IPP documentation accordingly. The QDDP will conduct weekly and monthly QA on the IPP records, along with staff observation, to ensure that all programs are implemented and documented on, as recommended. See attached in service record	7/18/11

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W 252	Continued From page 6 for June 2011. 3. Twice a month, with verbal assistance, the client will purchase a greeting card to send to his mother. Documentation was noted one time during the month of November 2010, December 2010 and January 2011. There was no evidence of documentation for April, May and June 2011. 4. The client will wipe his mouth when drooling is noted. There was no documentation for May and June 2011. Interview with the facility's qualified intellectual developmental professional(QIDP) on June 24, 2011, at approximately 1:00 p.m., revealed all staff were responsible for implementing and documenting Client #1's IPP progress. The facility failed to ensure consistent documentation of Client #1's IPP objective.	W 252		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation, interview and record verification, the facility failed to ensure that restrictive measures had been reviewed and approved by the facility's Human Rights Committee (HRC), for one of three clients in the	W 262	W 262 RN and QDDP were in serviced on HRC policy and procedure for restrictive measures. HRC approval was received on 7/13/11. The QDDP and RN will ensure that monthly QA is completed on the ISP and Medical records to ensure that all standards are met accordingly. See attached in service record and HRC approval	7/18/11

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W 262	Continued From page 7 sample. (Client #1) The finding includes: Observations during the medication administration, on June 23, 2011, at 5:35 p.m., revealed that Client #1 received Klonopin 1mg. Interview with the trained medication employee (TME) during the medication administration revealed that the client received the medication for maladaptive behaviors. Interview with the qualified intellectual disabilities professional (QIDP) and the review of Client #1's record on June 24, 2011, at approximately 10:30 a.m., revealed the client's behavior support plan (BSP) date July 16, 2010 addressed his targeted behaviors of physical aggression, verbal aggression, self-injurious behaviors, PICA, and bolting. The review of the HRC minutes on June, 24, 2011, at 10:24 a.m., revealed that Klonopin 1mg BID (twice a day) was reviewed and approved. However, review of the current physician order dated June 1, 2011 on June 23, 2011, revealed an order for Klonopin 1mg TID (three times a day). Interview with Registered Nurse (RN) on June 24, 2011, at approximately 5:30 p.m. revealed that Client #1 does receive Klonopin 1mg TID. Continued discussion with the RN revealed that the Klonopin 1mg TID was reviewed and approved, however, at the time of the survey, the facility failed to provide documented evidence of HRC approval.	W 262		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair,	W 436		

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W 436	Continued From page 8 and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Surveyor: 27828 Based on observation, staff interview and record review, the facility failed to ensure adaptive equipment were being furnished, monitored and maintained as recommended, for one of three clients in the sample. (Client #3) The finding includes: The facility staff failed to ensure consistent use of Client #3's eyeglasses as evidence below: Observation on June 23, 2011, at 4:11 p.m., revealed Client #3 playing the keyboard. At 5:08 p.m., the qualified intellectual disabilities professional (QIDP) placed the client's glasses on his face and asked, "did you forget to wear your glasses today?" Observation at the day program on the same day beginning at 10:50 a.m., revealed Client #3 did not have his glasses. Interview with the (QIDP) on June 24, 2010 at approximately 5:00 p.m., revealed that the staff forgot to prompt Client #3 to wear his eyeglasses. At the time of the survey, the facility failed to ensure Client #3 was consistently taught to use his eyeglasses.	W 436	W 436 All staff were re in serviced on individual's 'eyeglasses'. In the future the QDDP and the nurse will ensure that the individual's adaptive equipment is used consistently and is well maintained as per protocol. See attached – in service record	7/18/11

Health Regulation & Licensing Administration

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I 000	INITIAL COMMENTS Surveyor: 12301 A licensure survey was conducted from June 23, 2011, through June 24, 2011. A random sampling of three residents was selected from a residential population of five males with varying degrees of intellectual disabilities. The findings of the survey were based on observations, interviews with staff and residents in the home and at one day programs, as well as a review of resident and administrative records, including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Surveyor: 12301 Based on observation and interview, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure the interior and exterior of the facility were maintained in a safe and sanitary manner to meet the needs of five of five residents in the facility (Residents #1, #2, #3, #4, and #5) The findings include: On June 16, 2011, beginning at 3:15 p.m., the qualified intellectual disabilities professional (QIDP) accompanied the surveyor to conduct observations of the environment. The following concerns were identified:	I 090		

Health Regulation & Licensing Administration

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I 090	Continued From page 1 A. Exterior: 1. There were two long tears in the carpeting on the front steps. The carpeting was rolled downward slightly in the areas of the tears, which created potential trip hazards. 2. The surface of the front walkway was very uneven, and it appeared to have been recently repaired. Further observation of the end of the walkway, near the steps leading to the sidewalk, revealed it was slightly raised, which created a potential trip hazard. 3. The shingles on the edge of the roof, at the front of the GHPID were slightly raised. Observation of the interior of the facility revealed wrinkles in the paper on the basement wall, on the same side where the shingles were raised. Palpation of the wrinkled area revealed that the wall was soft. 4. A large amount of trash (wood, etc) was observed on the right side of the garage, which was located at the rear of the facility. 5. A section of the fence at the left side of the house was observed to have a warped board on top of it. The warped section was approximately two feet in length and curved upward, exposing the ends of the nails that previously secured the board in place. 6. Light was observed underneath the closed basement door. Further observation revealed approximately 1/4 inch of space beneath the door, creating the potential for pest to enter the facility. 7. The seat cushions were approximately four	I 090	I 090 A. Exterior 1. The carpeting has been fixed. 2. The front walkway has been re cemented. 3. The shingles have been replaced. 4. The trash has been removed. 5. The warped board on the fence has been replaced and there are no nails protruding. 6. The space beneath the door has been fixed. 7. The couch has been trashed. B. Interior 1. The molding has been replaced. 2. The space has been fixed. 3. The sliding closet doors have been fixed. 4. The drawers and chest knobs have been replaced. In the future the QDDP and the Maintenance manger will ensure that a monthly Environmental QA is completed to ensure that the interior and exterior of the house is safe and sanitary.	7/18/11

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I 090	Continued From page 2 inches longer than the front of the couch seat, which caused them to protrude beyond the edge of the couch. B. Interior: 1. A section of the molding (approximately 2 feet in length) was observed to be missing at the wall to floor junction in the laundry room in the basement. Interview with the maintenance supervisor indicated it was removed to assess the origin of water entering the area. 2. Light was observed underneath the closed basement door. Further observation revealed approximately 1/4 inch of space beneath the door, creating the potential for pest to enter the facility. 3. The sliding door in the bedroom of Residents #2 and #5 were off track and difficult to close. 4. Several drawer handles and knobs were noted to be missing from Resident #3's and #4's storage chest located in their bedroom. The missing handles and knobs were needed to easily open drawers.	I 090		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Surveyor: 27828 Based on observation, staff interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure adequate administrative staff to effectively meet	I 180		

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I 180	Continued From page 3 the needs of two of the three residents in the sample. (Residents #1 and #3) The findings include: 1. The facility's QIDP failed to ensure residents received continuous active treatment. (See Federal Deficiency Report Citation - W249) 2. The facility's QIDP failed to ensure program documentation was consistently collected. (See Federal Deficiency Report Citation - W252) 3. The facility's QIDP failed to ensure adaptive equipment was being furnished, monitored and maintained as recommended. (See Federal Deficiency Report Citation - W436) 4. The QIDP failed to ensure guidance to staff was accurate to consistently assist Resident #1 during mealtimes. Observation on June 23, 2011, at 6:09 p.m., the one to one staff attempted to hand Resident #1 a regular spoon. The qualified intellectual disabilities professional (QIDP) however, told the one to one staff to give Resident #1 his built up handle spoon. Continued observation revealed Resident #1 was eating pork chops, stuffing, and squash with the built up handle spoon. Interview with the facility's QIDP on June 24, 2011, at approximately 10:30 a.m. revealed that the resident could be given either a regular spoon or a built up handle spoon to utilize during mealtimes. Review of Resident #1's occupational therapy (OT) assessment dated July 29, 2010, on June 24, 2011 at 9:15 a.m. however, documented to "discontinue use of the built up utensil. Resident uses standard utensils	I 180	I 180 1. In the future the QDDP will ensure that all staff implement each individual's IPP – for drooling, according to the objectives. 2. In the future the QDDP will ensure that all staff implement the BSP as recommended and 1:1 staff remain within arms length of the individual at all times. The QDDP will conduct weekly and monthly QA on the IPP records, along with staff observation, to ensure that all programs are implemented as recommended. See attached in service record staff were re in serviced on individual's ~, tglasses'. In the future the QDDP and the nurse will ensure that the individual's adaptive equipment is used consistently and is well maintained as per protocol. See attached – in service record . In the future the QDDP will ensure that all staff utilize the appropriate eating utensils as recommended by the OT. The QDDP will ensure that monthly QA is completed on the ISP and IPP records to ensure that all standards are met accordingly. The QDDP will also complete weekly mealtime observations.	7/18/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0131	A. BUILDING _____ B. WING _____	06/24/2011

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I 180	Continued From page 4 effectively." At the time of the survey, the facility's QIDP failed to provide accurate guidance to staff related Resident #1's eating utensils.	I 180	1180 1-4. All staff were re-in serviced on the IPPs and program documentation. In the future the QDDP will ensure that all staff implement and complete IPP documentation accordingly. The QDDP will conduct weekly and monthly QA on the IPP records, along with staff observation, to ensure that all programs are implemented and documented on, as recommended. See attached in service record	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Surveyor: 12301 Based on interview and record review, the Group Home for Persons with Intellectual Disabilities (GHPID) failed to ensure each consultant had an annual health inventory. (C1) The findings include: During the entrance conference on June 23, 2011, at 10:10 a.m., the facility's qualified intellectual disability professional (QIDP) was requested to provide current health certificates for staff, consultants, and other professionals providing services to the residents at the home. On June 24, 2011, at 2:15 p.m., the review of the available health certificates determined that C1's health certificate was expired. Interview with the qualified intellectual disabilities professional (QIDP) on June 24, 2011, at 5:45 p.m., confirmed that a current health certificates was not available for the aforementioned consultant.	I 206	I 206 Health Certificate is attached. Metro Homes, Inc. is in the process of creating a new HR tracking and alerting system to alert management staff of expirations of licenses and certifications.	7/18/11

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I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 27828 Based on observation, staff interview and record review, the Group Home for Persons with intellectual Disabilities (GHPID) failed to ensure that residents received training, habilitation and assistance in accordance with their Individual Support Plan, for one of the three residents in the sample. (Residents #1) The findings include: 1. On June 23, 2011, at 3:30 p.m., Resident #2 arrived home from his day program. The resident was observed to drool heavily from 3:30 p.m. until he left for the Chateau at 6:45 p.m. During the observation, Resident #2's one to one staff did not hand the resident a paper towel to wipe his mouth until 4:13 p.m. (approximately 43 minutes). At 5:06 p.m., the QIDP asked the one to one staff to keep a napkin on hand to wipe the client's mouth. At 6:13 p.m., the QIDP asked the one to one staff to get a napkin and help Resident #2 wipe his mouth. The one to one staff wiped Resident #2's mouth then threw the napkin away. After being assisted, Resident #2 continued to drool without being encouraged to or assisted by his designated one to one to wipe his mouth. On June 24, 2011, at 11:45 a.m., review of Resident #2's individual program plan dated November 1, 2010, revealed an objective for the resident to wipe his mouth when drooling is noted.	I 422	I 422 Individual #2 **DOES NOT EXPERIENCE DROOLING AND DOES NOT HAVE A 1:1 STAFF. HE WAS NOT A RESIDENT AT THIS HOME IN Nov2010.** 1. In the future the QDDP will ensure that all staff implement each individual's IPP according to the objectives. 2. In the future the QDDP will ensure that all staff implement the BSP as recommended and 1:1 staff remain within arms length of the individual at all times. The QDDP will conduct weekly and monthly QA on the IPP records, along with staff observation, to ensure that all programs are implemented as recommended. See attached in service record	7/18/11

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I 422	Continued From page 6 Interview with the QIDP on June 24, 2011, at 10:18 a.m., revealed Resident #2's constant and heavy drooling was related to his medical diagnoses. The QIDP acknowledged that the client's drooling was a concern. When queried regarding the drooling program, the QIDP indicated that the program was conducted informally. Continued review of the client's record, including the IPP, however, failed to indicate the program objective was informal. At the time of the survey, the facility failed to ensure Resident #2 was provided supports to implement the aforementioned program as needed. 2. Interview with the qualified intellectual disability professional (QIDP) on June 23, 2011, at 10:15 a.m., revealed that Resident # 1 has a one to one staff to address his maladaptive behaviors of PICA, physical aggression, verbal aggression, self-injurious behaviors and bolting. On June 23, 2011, at 3:41 p.m., Resident #1 was observed to walk through the kitchen back door and stood outside on the backyard patio while his one to one was in the dining room. A few seconds later, the one to one staff looked up, then walked outside to the client. At 6:37 p.m., Resident #1 walked out of the dining room and into his bedroom while his one to one staff remained in the dining room. Approximately one minute later, the one to one staff was observed walking fast while looking in all the bedrooms until he located the resident in his bedroom. Review of Resident #1's behavior support plan (BSP) dated July 16, 2010, on June 24, 2011, at 10:00 a.m., confirmed the QIDP's interview of the aforementioned maladaptive behaviors. Further review of Resident #1's BSP revealed that the	I 422		

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I 422	Continued From page 7 "one to one staff should always be within arms length". The BSP also added that "the one to one staff should always remain vigilant and aware that [the Client] will attempt to run away from him and leave the premises". At the time of the survey, the facility failed to ensure that Resident #1's one to one staff implemented his BSP as recommended.	I 422		
I 999	FINAL OBSERVATIONS Surveyor: 12301 The following observations were made during the survey process. It is recommended that these areas be reviewed and determinations be made regarding appropriate actions to prevent potential non-compliant practices. On June 16, 2011, beginning at approximately 3:30 p.m., observation of the freezer located in the basement and the refrigerator section of the unit in the kitchen revealed they both lacked thermometers to monitor the internal temperatures.	I 999	. I 999 Both the fridge and the freezer currently have functioning thermometers. In the future the QDDP will ensure that this will be monitored at least monthly during the environmental QA.	7/18/11